Carolina Arthritis Associates, P.A.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Carolina Arthritis Associates to use and/or disclose certain protected health information (PHI) about me to:

RECORDS DEPOSITION SERVICE, INC.

(Name of entity/individual to receive this information.)

PO BOX 5054

(Address)

SOUTHFIELD, MI 48086-5054 **P: 248.357.3330 F: 248.357.3337**

(Address)

This authorization permits Carolina Arthritis Associates to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

FOR DISCOVERY BEFORE TRIAL

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on

Expiration of Date or Defined Event

Carolina Arthritis Associates, P.A.

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The Practice will ____ will not ____ receive payment or other remuneration from a third party for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Carolina Arthritis Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA.

PRIVACY RULE. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the **Privacy Officer** at:

Carolina Arthritis Associates, P.A.
1710 South 17th Street
Wilmington, NC 28401

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION.